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INSIDE ALEC

November/December 2008 A Publication of the American Legislative Exchange Council

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Chairman's Column

By Arkansas State Senator Steve Faris, Senate Majority Whip

It has been my honor to serve as your ALEC National Chairman this past year. I am very proud of the work we have accomplished, of all the new model bills our Task Forces have approved, and of all the ALEC members in state legislatures introducing these bills.

The strength of ALEC has always been in the new ideas and policy solutions that arise out of our unique public private partnership. Health care is one area in which the benefits of this partnership have really come to the forefront in recent years. As state legislators, many of us face growing demands for affordable health care solutions, at the same time we face shrinking state budgets.

In this special issue of *Inside ALEC*, we focus specifically on health and how the public and private sectors can work together to reduce costs and provide better access to health care for more people. ALEC Private Sector Members are leading the way in helping people afford their prescriptions. Many of us have already heard of initiatives to offer $4 generic drugs. Some of the nation's leading pharmaceutical companies are also working on other efforts to help eligible uninsured individuals save money on hundreds of prescription products.

ALEC private sector members are using new technology and innovative ideas to help lower costs and improve the quality of care for individuals. Efforts by public policy groups and others are also addressing the causes of high health care costs and offering viable solutions for policy makers at the state and federal levels.

ALEC has been a leader in promoting Health Savings Accounts and we are again in the forefront of the next big battle, cross-border purchasing of medical insurance. This is an issue which came up during the Presidential debates. Of course, ALEC already had a model bill, Health Care Choice Act for States, promoting freedom of choice for individuals.

Merrill Matthews, Executive Director of the Council for Affordable Health Insurance, an ALEC member, wrote in the *Wall Street Journal* in October in support of the Health Care Choice Act. This bill now before Congress would allow individuals living in one state to purchase health insurance being sold to people living in other states. The increase in competition would lower prices and give individuals more choices and more control over their health insurance decisions.

ALEC Calendar

December 4-6, 2008	States & Nation Policy Summit	Washington, D.C.
May 1-2, 2009	Spring Task Force Summit	Memphis, TN
July 15-18, 2009	ALEC Annual Meeting	Atlanta, GA
December 2-4, 2009	States & Nation Policy Summit	Washington, D.C.

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Cigarette Taxes: No Answer for State Budget Woes

Will Kansas Learn From Maryland?

By Jonathan Williams

Once again, a politician has decided to take aim at "Big Tobacco"—this time, it's Kansas' own Kathleen Sebelius. During a recent press conference, Governor Sebelius said she supports a 50 cent per pack cigarette tax increase. Not to be outdone, the Kansas Health Policy Authority subsequently proposed hiking the tax by 75 cents per pack to pay for new spending on health care programs. Unfortunately for the governor and the authority, hiking taxes on smokers is one of the least effective ways to raise long-term revenue for the state.

Cigarette taxes always look attractive to lawmakers on paper, as revenue forecasters often show a windfall of projected receipts from the tax. However, in the real world, people respond to incentives and cigarette taxes have been shown to encourage smokers to avoid high-tax jurisdictions. As state after state has learned, the promise of substantial cigarette tax revenue often goes up in smoke.

Take the state of Maryland for example. Last year, state lawmakers doubled the state's cigarette tax to $2 per pack in an attempt to pay for additional health care and balance the budget. Of course they expected a revenue boom, but they were sorely mistaken. The Wall Street Journal reports that cigarette sales are down 25 percent. In fact, nearly 30 million fewer cigarettes have been sold in Maryland since the tax increase this year. Therefore, the cigarette tax, which was supposedly the panacea for the state's budget woes, has come up short, and lawmakers in Annapolis are back to the drawing board.

Retailers in Maryland have seen their cigarette sales plummet because of good old fashion competition—and in this case, specifically tax competition. Just across the Potomac River, Maryland residents can take full advantage of the lower taxes in Virginia. Maryland's neighbor to the south has one of the lowest cigarette taxes in the nation at 30 cents per pack. Such a cost difference with a bordering state has made it profitable for Maryland drivers to venture down Interstate 95 into the Old Dominion, saving $1.70 a pack in cigarette taxes alone. Maryland has responded with hopeless attempts to control out of state cigarette purchases with investigations and searches of suspected "tax evaders" on the border.

Only a few states in the nation have lower cigarette taxes than Virginia. Unfortunately for Governor Sebelius and the other cigarette tax hikers in Kansas, neighboring Missouri is one of them. The Show-Me State levies a tax of only 17 cents per pack of cigarettes, which is the second lowest cigarette tax in America.

With competitors like these sitting just across Kansas' border, it should make every policymaker in Topeka very aware that changes to policy are not created in a vacuum. Every time a state changes tax policy, it directly and immediately influences the incentives of individuals and businesses—in this case, smokers.

If the Kansas Health Policy Authority is successful, and Kansas lawmakers adopt the proposed 75 cent per pack cigarette tax increase, the tax would increase to $1.54 per pack. At that point, the tax cost per pack of cigarettes would be $1.37 lower in Missouri—not to mention Kansas' tax would be the highest of any bordering state.

As lawmakers in Maryland have painfully learned, states cannot expect that cigarette taxes will raise enough revenue to solve budget problems. Furthermore, states cannot expect smokers to ignore the incentive to purchase their cigarettes in bordering states—especially when that incentive is high enough.

Unfortunately, with politically charged topics such as these, it is easy for some public policy leaders to lose sight of basic economic realities. However, it is clear that the proposed tobacco tax increase will fail to raise the revenue suggested. Not only will consumers have a greater incentive to purchase their cigarettes across state lines, today they can evade the increased taxes in the comfort of their own home, through the Internet.

Politically, cigarette taxes are an easy sell; however, cigarette taxes are strikingly bad public policy.

Jonathan Williams is the Director of ALEC's Tax and Fiscal Policy Task Force.

Keeping the Patient in the Center of Health Reform

By Alex M. Azar II

Amidst recent calls for health care change, the concept of evidence based medicine, or EBM, is often touted as the latest way to improve health quality while decreasing costs. Look at the evidence, proponents say, develop practice standards, and hold physicians to those standards. Some proponents take an additional step to suggest only paying for that which falls within the standards. On its face, this may sound good. But done incorrectly, or merely for cost savings, EBM could jeopardize the traditional doctor-patient relationship and ultimately worsen patient outcomes. At its heart, EBM should not be about budget-based medicine. EBM should simply be about using the best clinical evidence to improve individual patient results.

Another related term often heard in health policy circles is comparative effectiveness research or CER. CER essentially means comparing the clinical effectiveness, risks, and benefits of different options for treating a particular medical condition. CER has become popular recently, propelled in part by calls for a government-run center to conduct and manage it nationally.

Both EBM and CER are already part of the health system. Doctors practice evidence-based medicine every day, and CER is currently being done in the marketplace by those who have incentives to do it, like big health insurance companies, universities, and product manufacturers. EBM and CER are tools in the kit to improve the way health care is administered and to manage quality performance.

Moving forward, CER can be an important tool to improve patient outcomes, but like its EBM cousin, care must be taken that it is done with the individual doctor-patient relationship, treatment choice, and patient outcome as its driving forces. Done incorrectly, CER also has significant limitations and risks. Examining the potential and the pitfalls for CER is worthwhile.

CER should be aimed at improving the quality of health care. At its best, CER develops population-level information that is translated into practice standards

to serve as references for doctors in deciding the best individual course of treatment. As policy makers, it is important to ensure a health system that fosters improved medical standards, but also allows and protects individual decisions about treatment and cost.

Health care innovation is leading to more personalized care, and biopharmaceutical science is no different. Drug development is advancing, along with advances in genomics, toward a more tailored therapeutic approach. Tailored therapies may be one of the best opportunities to improve patient care—by matching the right patient with the right medicine, at the right time, and at the right dose. CER should support these advances in science.

How can CER best support health care transformation? From the larger health system view, CER can identify potential targets for improvement. For example, research shows that Medicare spending varies greatly in different regions—and even in different parts of some states—yet patient outcomes are not notably different. Employing CER broadly, across multiple

parts of the health system, to evaluate these differences may reveal opportunities for substantive change, both behavioral and systemic. To tackle these larger systemic issues, CER needs to be conducted across a broad spectrum of health care services, from medicines to diagnostics, services, procedures, and benefit designs. Improved standards of medical care—guidelines for health practitioners—that emerge from comparative research, coupled with health information technology (HIT)—such as electronic medical records—and other vehicles of communication and management, should help reduce local variations in care, improve outcomes, and reduce costs across the system.

CER is not an end in itself. It provides information to the system. For transformation to take hold, CER must be trustworthy because important decisions are at stake. Patients and doctors decide whether to have surgery or therapy; payers decide whether to pay for one procedure instead of another; manufacturers may decide whether or not to invest in a new product. Researchers, physicians, patients, manufacturers, and health plans should all participate in CER in order to translate research into better and more affordable clinical practice today, and improve the next generation of science.

How is CER translated into better medical practice? CER is about aggregate outcomes. However, using CER to over-generalize health care is in conflict with the growing personalized nature of treatment and flies in the face of scientific progress. That is the wrong direction for health care to go. CER should be additive to the body of medical evidence and not definitive. Think about it. The "Today" show tells us on Monday about a study that drinking coffee is bad for us, and on Friday we'll hear about another study that coffee is good for us. Science is dynamic, and the current market-driven system of CER is dynamic.

In my role as Deputy Secretary of HHS, I noted the potential for the marketplace to move toward value-driven healthcare. But it's not clear that there is a government role needed here. A 2008 report generated for the Medicare Payment Advisory Commission noted that any center performing CER "should have high visibility, credibility in the research and healthcare communities, and independence from political influence." The report then stated that existing agencies would have difficulty assuring all three of these objectives. The legitimate concerns over credibility and independence include whether a single government agency would try to mandate one right answer, for everybody, regardless of their unique medical circumstances.

If there is a government role for CER, it would at most be to assist with funding studies that individual companies might not have financial incentives to study, in much the same way that government funds basic research through the National Institutes of Health. The government should not take control of CER. A federally created or supported CER agency should sponsor universities, institutions, and private researchers to study broad health care issues that add to our understanding of the greater health care system—topics like HIT application, benefit design, and geographic variations in care. Doing so will respect the competitive and dynamic nature of science and allow creative innovation to flow. The government could also facilitate the dissemination of information to patients, health care professionals, and other stakeholders as a benefit to the marketplace.

A government entity should not have a role in making or recommending payment or coverage decisions. Rigid translation of CER into broad population-based reimbursement and access mandates will lead to patients and physicians losing control of health decisions. Competition among private health plans for beneficiary dollars causes each insurance company to internalize patient preferences—and market health plans to those preferences. It's the key genius of our system. A single, centralized CER decision is static and would have harmful implications to our health system by leading to more uniformity in approach and less benefit package competition among health insurance companies as they compete for beneficiary dollars. In this scenario, patients will lose.

Such a position is consistent with leading proponents of a CER agency and allows market participants to continue to do cost/benefit analyses that are most relevant for their covered populations. Decisions about formularies and covered treatments will remain an accurate reflection of value—not an artificial assertion by a one-size-fits-all central bureaucracy. In this way, patients are more likely to get the right treatment for their individual needs and circumstances.

Alex M. Azar II is Senior Vice President of Corporate Affairs and Communications for Eli Lilly and Company. Prior to his position at Lilly, Mr. Azar served as Deputy Secretary and General Counsel of the United States Department of Health and Human Services.

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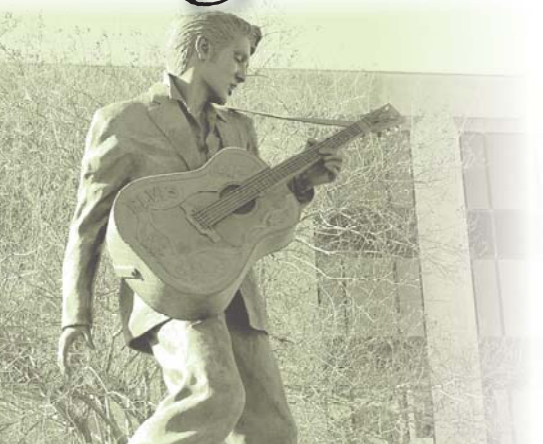

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Presidential Poison or Cure:
Getting to the Bottom of Health Care Costs

By Byron Schlomach, Ph.D.

Just as medieval bloodletting harmed the patient due to the misdiagnosis of "bad humors" in the blood, the wrong diagnosis of our health care cost problem could lead to a deadly prescription.

The correct explanation of why health care costs are so high and continue rising faster than general inflation makes a big difference in the prescription to cure the problem.

There are two competing views of what ails our health care system. They could both be wrong, but they cannot both be right.

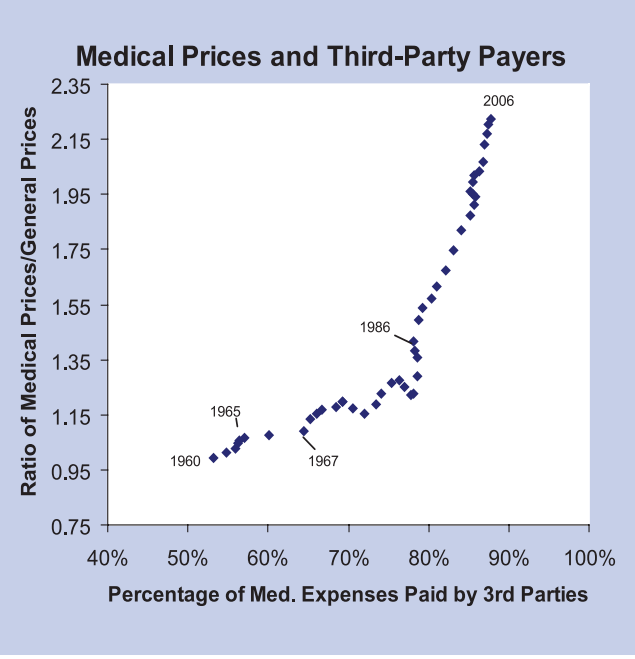
One view is that a market system in health care is unworkable. Because health care is so basic a need, it cannot be subjected to the laws of economics. People are often desperate and because they lack expertise, they will pay any price and will be preyed upon.

This explanation for rising health care costs naturally leads to prescriptions like those offered by presidential candidate Barack Obama. He would require and subsidize pre-paid-style health insurance for children and expand Medicaid, staying on the same path we've been on, with government taking increasing control of our health care choices.

The other view of what ails health care holds that the problem lies with our *failure* to rely on markets. The current health care system, where consumers are insulated from the costs of services they consume by having third parties pay the bills, like private insurance companies and the government, is not a market. Government pays for health care for tens of millions of people through Medicare and Medicaid, and tax policy pushes people into employer-financed pre-paid-style health insurance. Since consumers are insulated from the cost of medical services, their demand is artificially high and health producers can charge whatever this distorted market will bear.

The third-party-payer explanation for rising health care costs naturally leads to prescriptions like those offered by presidential candidate John McCain. He would change the tax code to separate a person's health insurance coverage from their employer. He would increase reliance on health savings accounts, increase co-pays for Medicaid recipients, and reduce state health insurance regulation to lower the costs of catastrophic policies.

So what is the right diagnosis and prescription for fixing the health care cost crisis? For the first diagnosis, most of our evidence is anecdotal; like *The Pearl*, a novel by John Steinbeck that tells the story of an unscrupulous doctor who, in order to get a rare, black pearl, takes advantage of a poor fisherman whose son is ill. For the second diagnosis, our evidence is this graph.



This is not a statistically derived curve without the usual scatter plot of the data. It *is* the scatter plot. The graph categorically shows that as the share of medical expenses paid by government and private employer-provided pre-

paid-style insurance has risen in the United States, the relative price of medical care compared to general prices has risen geometrically.

The statistics for the proportion of health care expenses paid by various parties reach back to 1960 and are from the Centers for Medicare and Medicaid Services' National Health Expenditures Accounts. They show that throughout the 46-year period, from 1960 to 2006, the proportion of health care expenses paid by third parties has significantly increased from 53 percent in 1960. The biggest increase occurred in 1966 and 1967 as Medicaid and Medicare were put in place. By 1986 fully 78 percent of total health care expenses were paid indirectly by third parties. By 2006, it was an astounding *88 percent*.

The vertical axis shows the ratio of medical care prices divided by general prices using the Medical Care Price Index and the Consumer Price Index from the Bureau of Labor Statistics. The medical price data stretch back to 1935, so the resulting ratio is normalized to equal one in 1935.

The data show that in 1960, the relative price of medical care was about the same as it was in 1935. In 1986, after a period of general price instability, the ratio stood at 1.42. The relative price of medical care had risen more than 42 percent since 1960. In 2006, the relative price of medical care stood at 2.22, more than doubling the general price level's increase since 1960. The relative price of health care was more than 122 percent higher than it was 46 years earlier.

These relative price data indicate that if the price of health care was that of 1935, it would only consume 7.2 percent of our GDP, instead of the current 16 percent. In fact, if relative health care prices fell to those of 1952, when they started their long march upward along with the increasing prevalence of employer-provided pre-paid-style health insurance, health care would only be 5.9 percent of GDP. Think of what could happen to the economy if 10 percent of GDP were freed up.

The data in the graph show that as government and private pre-paid health insurance plans have picked up more of the health care tab, medical prices have been pulled higher by the artificial increase in demand.

While this is hardly a shocking revelation, up to now, evidence of this has been anecdotal and circumstantial. Comparing two time series as this graph does can be tricky, but other proposed causes for health care cost increases, like improved technology, do not satisfy. They violate known experience in every other market throughout the history of the world.

We have a clear choice. Either we cure what ails us or we bleed out in the name of punishing the bad humors.

Byron Schlomach, Ph.D., is the Director of the Goldwater Institute's Center for Economic Prosperity, in Phoenix, AZ. www.goldwaterinstitute.org.

The Evolution of Evidence Based Medicine

By Jim Carey and Joanne Chang, M.D.

EBM is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research.
- Dr. David Sackett, 1996[1]

Evidence based medicine (EBM), when used appropriately, integrates clinical expertise, patient values, and the best evidence into the decision making process for patient care. The idea began in the 1970s at McMaster University in Canada and was formally recognized in the early 1990s in the Journal of the American Medical Association.

The promise of EBM is that it allows healthcare professionals to use science, engineering, and statistical techniques (such as meta-analysis of medical literature), risk-benefit analysis, and randomized controlled trials, to make "conscientious, explicit, and judicious use of current best evidence" in their practices.[2] Drawing from the large body of evidence from medical research, healthcare professionals have information to help them correctly diagnose illnesses and choose the best treatment plan and methods of disease prevention for individual patients.

EBM Today

Uses of EBM today are beginning to demonstrate positive results. Practice guidelines developed using evidence based medicine have helped to reduce mortality of heart attacks. EBM guidelines have also improved care for patients with diabetes and other chronic illnesses.[3]

However, criticism in this area has been fairly well documented. It has been argued that the term "EBM" has been misused, and practices used to drive what many refer to as "cookie-cutter" or "cookbook" medicine, where the individual characteristics of patients are less considered, are sometimes performed under the guise of EBM.

But focusing on the positive aspects of its applications, it's clear that evidence-based medicine and its various iterations are here to stay. It's also increasingly apparent that entities considering various initiatives need to focus on overall value and quality of programs for patients, and not just using EBM to contain healthcare costs. Real EBM innovation is coming, too.

Comparative Effectiveness Research (CER)

One such initiative that has grown out of evidence-based medicine is comparative effectiveness research (CER). CER evaluates the impact of different options for treating a given medical condition for a particular set of patients. And it has caught the attention of Congress. The Comparative Effectiveness Research Act of 2008, sponsored by Sens. Kent Conrad (D-ND) and Max Baucus (D-MT), would establish an institute to evaluate the effectiveness of different drugs, medical devices, treatments, and procedures that exist for the same illness. The principle idea is to promote value in the use of health care interventions.

In "A View from the Congressional Budget Office," from a 2007 New England Journal of Medicine article they authored, Congressional Budget Office (CBO) Director Peter R. Orszag, Ph.D., and analyst Philip Ellis, Ph.D. opine how EBM can help control Medicare and Medicaid costs. They cite expert's estimates that less than half of all medical care in the U.S. is based on evidence of effectiveness. The CBO article contends that reimbursement incentives can subtly drive doctors towards treatments that provide greater compensation. They suggest that expanding research into comparative effectiveness would better align patient and physician incentives and eventually reduce costs.[4]

An Example: The Drug Effectiveness Review Project

The Drug Effectiveness Review Project (DERP) is a self-governing collaboration of public and private organizations, including 14 states. They have joined together to provide systematic, evidence-based reviews of the comparative effectiveness and safety of drugs in many widely-used drug classes, and apply the findings to inform public policy and related activities in local settings. DERP pioneered the application of systematic reviews to drug coverage decision making in the U.S. It was originally developed in the state of Oregon to help manage Medicaid costs.[5] Other state Medicaid programs joined to inform pharmaceutical cost containment policies with clinical evidence, using DERP for their restricted drug formularies, called Preferred Drug Lists (PDLs), for example.

DERP is controversial. So far, the majority of DERP reports do not show specific differences between drugs within the same class, or they conclude that there is not enough evidence to draw conclusions. DERP reports have provided little information to physicians and patients as to which treatment options are best for them. As a result, DERP reports are said to have been used to support more "cookie cutter" policies in the states that utilize the reports. While the DERP reports themselves do not make specific recommendations for coverage or reimbursement policies, Medicaid agencies of the states affiliated with DERP use the reports to drive cost containment through their PDLs.

Much More than Cost Containment

But CER initiatives such as DERP offer far more potential than just the evaluation of drugs for PDLs. That's too narrow a focus, and doesn't account for its potential for clinical use and policy decision making. EBM and CER initiatives like DERP should be focused on enhancing healthcare quality and patient outcomes, not just cost containment.

Any new government-affiliated entity focused on CER, such as that proposed by Senators Conrad and Baucus, must be accountable, independent, and credible–like an independent, public-private partnership. Emphasis should be on comparative clinical effectiveness–not the economic priorities of payers. Besides pharmaceuticals, research should include services, including disease management, medical and surgical procedures, diagnostics, medical devices and healthcare delivery methods.

More Innovations in EBM

Evidence based medicine can be leveraged in many innovative ways, using data to improve patient quality of care along as well as overall value.

- In Connecticut, Pitney Bowes pioneered an initiative called value-based insurance design (VBID) which advocates that copayment rates be set based on the value of clinical services in benefits and costs, and not just the costs. Pitney Bowes lowered barriers to treatment of chronic illnesses by reducing copayments for all users of drugs commonly prescribed for certain chronic diseases, like diabetes, asthma, and hypertension. VBID has been vetted academically and piloted with a number of employers.[6] It is an emerging and promising trend.

- There are other examples of better care coordination through evidence based initiatives. For instance, Medicare Part D Sponsors are required to establish a Medication Therapy Management Program (MTMP) designed to ensure that covered Part D drugs are appropriately used to optimize therapeutic outcomes through improved medication use and reduced risk of adverse events.[7] Every spring, the Centers for Medicare and Medicaid Services evaluates and approves Part D sponsor's MTMP for compliance with the current minimum requirements for the upcoming program year. Part D sponsors can develop and implement an MTMP that can best meet the needs of their specific patients and achieve the best therapeutic outcomes.

- Pay for performance (P4P) rewards providers for quality of healthcare services. Integrated Healthcare Association (IHA) is a coalition in California of health plans, medical societies, healthcare systems, and academic, consumer, purchaser, and pharmaceutical representatives. They recognize physician groups who achieve a certain threshold based on clinical criteria. Financial incentives are rewarded to physicians by the plans. Over $210 million total has been

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Throwing the Flag on Government Interference in TV Marketplace Negotiations

By Seth Cooper

Imagine watching your favorite professional football team battle their way into overtime, only to see the referees rule that their opponents now get to call the plays for both teams. Strangely enough, the NFL has been urging states to adopt similar kinds of rules in its disputes with cable operators who carry professional football games. The NFL has called for state legislation to mandate negotiating processes hedged to give independent programmers an advantage over cable operators. But the powers of government shouldn't be used to pick winners and losers in the marketplace by twisting the arbitration process. Private parties should be able to negotiate contractual terms on their own.

The Marketplace at Work

The free market system for negotiating between cable operators and independent programmers is in large part responsible for the rise of over 550 national programming networks. Today, the programming content of these networks includes news, public affairs, weather, shopping, religion, education, sports, history, nature, food, music, and more. What's more, independent programmers negotiate with a variety of competing video distributing platforms, including Direct Broadcast Satellite and telephone companies.

Cable operators offer customers multi-channel packages, many of which carry both independent programming and content originated by the cable operators or their subsidiaries. For instance, TimeWarner Cable provides customers with independent programming as well as programming from the networks it owns; namely, CNN, Headline News, TBS, and TNT. Similarly, Comcast and Cox Communications typically offer customers ESPN for sports programming, but also make available their own sports networks—Comcast SportsNet (or CSN) and Cox Sports Television (or CST). As a result, content offered by independent programmers is sometimes unique, but other times cable operators' own programming directly competes with particular audience segments.

Both cable operators and independent programmers typically reach commercial carriage agreements through hard bargaining. Such bargaining involves particularized weighing of the perceived value of such programming in light of innumerable factors such as bandwidth availability, consumer demand, and available alternatives—including programming a cable operator already carries. Depending on the negotiated price, cable operators will place such independent networks either on a basic, extended programming tier of channels or on a specialized, smaller tier of premium channels that costs customers extra. For instance, Fox News Channel or the Discovery Channel demand less money for carriage by cable operators, and so it is commonly placed on a basic tier of channels. HBO and Showtime, by contrast, demand more money from cable operators, and so they are placed on specialized tiers for customers who chose to pay extra for premium programming.

NFL Networks' Controversy

Millions of fans watch professional football games through over-the-air broadcasts on major networks, direct satellite broadcasts, telecom video distributors, or through basic extended programming packages offered

by cable operators. To view additional NFL games from their homes, some die-hards subscribe to the NFL Network. It's a channel that cable operators place on premium tiers. But controversy arose this past year when the NFL demanded that cable operators who own competing programming place the NFL Network on their basic extended tier. This despite the higher cost of the NFL Network compared to typical basic extended tier channels. Understandably, cable operators chose not to saddle themselves or their standard tier customers with extra costs, declining to give the NFL Network special treatment.

Last season, the NFL broadcasted select football games only on the NFL Network. Football fans in states such as Texas and Wisconsin that did not subscribe to the NFL Network were unable to watch their local teams play some of those exclusive games. When the NFL's hopes to gin up viewer complaints fell flat the NFL decided to forego additional negotiations and sought government interventionism.

States Consider Mandatory "Arbitration" Proposals

Rather than redouble efforts to resolve its dispute with cable operators through private negotiation, the NFL turned to state governments for leverage. In the last year, legislatures in states such as Illinois, Indiana, Ohio, North Carolina, South Carolina, Wisconsin, and Texas considered proposals requiring independent programmers such as the NFL and cable operators to enter into a special, binding "arbitration" process. Legislative committees in some of the states held hearings to consider the disputes between independent programmers and cable operators. Other states saw bills introduced to establish a statewide process for programmer-cable operator compelled "arbitration."[1] However, none of the states that considered such proposals ever passed them into law.

First to File Gains Unfair Advantage

A serious problem with the recent state legislative proposals is that they would mandate a highly dubious process that vaguely resembles "arbitration." To take a legal dictionary definition, arbitration is "a method of dispute resolution involving one or more neutral third parties who are usually agreed to by the disputing parties and whose decision is binding." Private parties often resort to this process when they are unable to reach an agreement on their own in the marketplace. But these state legislative proposals hedge the process in favor of independent programmers such as the NFL.

Under the NFL's game-plan, whenever a party offering programming competes with a cable operator that provides similar programming, one of the parties can demand and receive "arbitration" whenever it feels it's being treated unfairly. A party that "has reason to believe that it has not been treated in a fair, reasonable and non-discriminatory manner concerning carriage of a competing programming channel" in an unresolved dispute may file a formal arbitration demand along with its "final offer" price. Strangely, the process gives a special advantage to the party filing for arbitration: they win the fight over contract terms and conditions simply by filing first. The arbitrator must make a ruling using only the terms and conditions offered by the filing party. By

contrast, the defending party is only able to counter-offer with its own price—based on those same terms and conditions now set in stone by the filing party. Based on the filing party's suggested terms and conditions, the arbitrator is required to side with the price offer that "most closely approximates the fair market value of the programming carriage rights at issue." The arbitrator has no discretion in determining price.

This easy avenue to arbitration on terms and conditions set by the filing party significantly reduces the incentive of independent programmers to reach private agreement if their first offer is rejected by cable operators. Independent programmers would have nothing to lose by invoking the process. Cable operators, however, would lose their commercial and editorial rights to best ascertain whether consumers will demand particular programming or how to competitively offer consumers the best programming value for their dollar.

Existing Federal Law Provides Protections

Importantly, new state laws aren't necessary to contend with alleged discrimination and anti-competitive behavior by cable operators. Federal law already provides protection in many instances where an independent programmer such as the NFL feels it is being unfairly discriminated against. According to section 616 of the 1992 Cable Act and related regulations, discriminatory and anti-competitive behavior by cable operators is prohibited.[2] The Federal Communications Commission (FCC) is entrusted with enforcement. Under the federal law, independent programmers allegedly harmed can file complaints to the FCC. In those situations, they must demonstrate discrimination or anti-competitive practices by cable operators.

Government intervention in the free marketplace should require real evidence of harm. Such intervention shouldn't be triggered just where one party to a private agreement doesn't get what it wants. Independent programmers know that a demonstration of discrimination or anti-competitive behavior requires real evidence under federal law. The standard set out in federal law goes some way in filtering out instances where one well-bankrolled party simply gets greedy and wants too much money for its services. But a

showing of evidence isn't required under the recent state legislative proposals for arbitration. Under the state legislative proposals, a party simply needs to make an assertion of unfair treatment. This strongly suggests that the state legislative proposals are designed to give independent programmers an advantage over cable operators that federal law does not provide.

Federal Jurisdiction Over Cable Program Carriage Agreements

Federal law occupying the field of cable regulation would certainly render void all of the recent state legislative proposals for mandating "arbitration" in disputes between cable operators and independent programmers. When Congress enacted the Cable Communications Policy Act of 1984, it adopted a comprehensive framework for regulation of cable. Congress gave the FCC exclusive jurisdiction over cable. State jurisdiction was limited to such areas as franchising, rights-of-way, and consumer protection.

The U.S. Constitution would not permit state arbitration mandates for program carriage because the Congress and the FCC already regulate program carriage agreements and promotion of competition in delivering diverse sources of video programming. State laws frustrating federal policies are preempted under the Article VI Supremacy Clause. Moreover, the 1984 Cable Act provides that "[a]ny Federal agency, State, or franchising authority may not impose requirements regarding the provision or content of cable services, except as expressly provided" in the Act

itself.[3] Accordingly, not only does existing federal law governing program carriage disputes make state arbitration mandates unnecessary, federal law governing cable also makes such state government intervention impermissible.

Undue Process at the FCC?

Recent actions at the FCC have put a cloud over its involvement in the NFL's dispute with cable operators. This year the NFL filed a discrimination complaint against Comcast. FCC Chairman Martin pressed Media Bureau staff to unilaterally rule in favor of the NFL in October. Disconcertingly, this would have shut out the other four FCC Commissioners from any vote on the staff's ruling. More disturbing, such a staff ruling would have completely bypassed adjudication by an administrative law judge, routine for many such complaints. However, the four dismayed Commissioners fired a joint communication to Martin, insisting the matter be turned over to an administrative law judge. The complaint is now slated for an administrative law judge's review.

ALEC's *Resolution* Calls for Marketplace Freedom

In May, ALEC's Telecommunications and Information Technology Task Force adopted a *Resolution Opposing Government Involvement in Commercial Negotiations*. The *Resolution* recognized that "a myriad of programming choices have resulted from the successful private negotiation of contracts between program networks and video distributors without government interjection requiring the parties to submit to mandatory arbitration." It also declared that "parties ought to be free to negotiate without the threat of government intervention tipping the scales in one party's favor." The *Resolution* resolved that "ALEC calls upon the government to oppose efforts to adopt legislation requiring mandatory arbitration to resolve commercial disputes." By this *Resolution*, members of ALEC put all state legislators on notice to beware of this kind of heavy-handed intrusion by government in the marketplace.

Looking Downfield to 2009

When state legislatures go back into session early next year, they should say "no" to compelled pseudo-arbitration of cable programming disputes. Government shouldn't be involved in marketplace disagreements, but respect the commercial rights of private parties. States should also say "no" to dispute resolution processes that aren't nearly so neutral as one would expect. The law should allow for a fair game and not give the NFL a home-field advantage.

Seth Cooper is the Director of ALEC's Telecommunications and Information Technology Task Force. ALEC's Resolution Opposing Government Involvement in Commercial Negotiations is available to members at www.alec.org.

1 *See* IN HB 1138 (2007); MN HB 3212 (2007); OH HB 377 (2007); SC S. 989 (2007); SC HB 4374 (2007); WI S. 343 (2007).

2 47 U.S.C. § 536; *Impelementation of Sections 12 and 19 of the Cable Television Consumer Protection and Competition Act of 1992*, 9 FCC Rcd 2642, 2648 (1993); 47 C.F.R. § 1701-1702 (2008).

3 47 U.S.C. § 544(f)(1).

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Continued from page 10

rewarded to physicians in 235 medical groups representing approximately 40,000 physicians.[8]

- A medical home provides individual-centered care in primary care settings. It's a model that organizes care around relationships between the patient and the personal clinician.[9] The Geisinger Health System in Pennsylvania reduced hospital admissions by 20 percent and saved 7 percent in total medical costs by providing a patient-centered medical home model of care, according to first-year results from pilot test sites. Under the pilot project, Geisinger provided monthly incentive payments of $1,800 to participating physicians and $5,000 monthly stipends for every 1,000 Medicare patients served to help practices finance additional staff and extended hours.[10] Geisinger's model included around-the-clock access to primary and specialty care, physician and patient access to electronic medical records (EMRs), and the use of nurse care coordinators and a "personal care navigator" to answer patient questions. Reflecting on the success of the program, which Geisinger plans to expand to include 10 other clinical sites, Geisinger CEO Glenn Steele, Jr. MD says the results are "probably one of the most dramatic things I've seen in 30 years of practice and leadership" and "point to the potential for innovative and integrated delivery systems to improve health care quality."

As stated, this is just a beginning. There are many other ways that EBM can be leveraged. Examples such as VBID and the medical home offer glimpses of the future. As Congress considers legislation on evidence based medicine and comparative effectiveness research, it is critical not only to include a comparison of various treatment options, but also to assess the comparative benefit of various case management services, formulary and benefit designs, and structure and networks of delivery that affect care patients receive.

Jim Carey is Executive Director of Health Policy, and Joanne Chang, MD, is Vice President of Evidence Based Medicine at Novartis Pharmaceuticals Corporation, located in East Hanover, NJ. The Novartis Group companies provide healthcare solutions that address the evolving needs of patients and societies. Focused on growth areas in healthcare, Novartis offers a diversified portfolio to best meet these needs: innovative medicines, cost-saving generic pharmaceuticals, preventive vaccines and diagnostic tools, and consumer health products. Novartis is the only company with leading positions in these areas. With worldwide headquarters in Basel, Switzerland, Novartis Group companies operate in over 140 countries around the world. www.novartis.com.

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Member News

New Mexico State Senator Steve Komadina Speaks on Education Issues

The University of Phoenix hosted New Mexico State Senator Steve Komadina at its new building in Albuquerque on October 1, 2008. Sen. Komadina addressed current and prospective University of Phoenix Albuquerque students on the importance of pursuing higher education in today's tumultuous economic times. His presentation was based on the information he heard at ALEC's Annual Meeting from Dr. Richard Vedder on higher education (workshop and meal session). A state senator since 2000, an obstetrician since 1970, and an active community leader and volunteer, Sen. Komadina has fought for legislation to bring more doctors to New Mexico and co-sponsored bills to eliminate gross receipts tax on food and doctors visits.

Nebraska Senator Pat Engel to Retire

ALEC's Vice National Chairman, Nebraska Senator Patrick Engel is retiring this year after serving15 years in the legislature. Originally appointed in 1993 to fill a vacated seat in the legislature, Engel went on to be re-elected four times. He served as the Chairman of the Nebraska Executive Board and Reference Committees and also served as a member of the Appropriations, Committee on Committees, and Legislative Performance Audit Committees.

Before joining the legislature, Sen. Engel was an insurance agent for State Farm Insurance and served as a Board Member for the South Sioux City School Board and as Dakota County Commissioner.

ALEC International Update

The Legacy of Coordination

By David Stott

The inherent ties between the United States and Europe are historical, cultural, political, and, most importantly, economic. We share a billion dollar a day trading relationship—our history links our past, our trade links our present, and, as the current U.S. financial crisis creates a domino-effect crisis in Europe, it is very clear that our futures are fundamentally linked too. During times of worldwide economic uncertainty, the need to strengthen cooperation and forge closer links between Jeffersonian-minded policy makers, at home and abroad, has become a high priority.

Dan Hamilton, a leading expert on the transatlantic economy, notes that we find ourselves in a situation where the deficits affecting our economic partnership are not of trade, investment, or values but rather a deficit in understanding amongst political and corporate leaders the extent of how much one economy's success relies on the other.

In the midst of the recent economic crisis it appears that valuation fundamentals are being thrown out the window. Governments are, understandably, eager to act in order to avoid mistakes made in the 1930s during the Wall Street crash. Whether the banks need the government to save them from their own mistakes or not, the confidence of American and European citizens needs to be strengthened in conjunction. It appears that not even a $700 billion bailout package is enough to calm the nerves of consumers or aid in stabilizing the world economy. So what should happen next? In order to fully realize a broad and profound free market that improves the confidence of consumers, we need to activate strong leadership and coordination from legislators and business communities on both sides of the Atlantic. Now, more than ever, conservatives in the US and Europe must come together to challenge advocates of over-taxing, over-borrowing, and over-governing.

ALEC members have always been outward-looking and prepared to play a full role in world affairs. Free trade is central to ALEC's vision of the way nation states should relate to each other. Strong economic growth in the U.S. has been a key catalyst in boosting corporate earnings in Europe which in turn has helped promote more investment and employment growth across the region—reciprocally, when there are downturns in the US economy, Europe shares a similar burden—making it imperative that legislative members across the Atlantic connect with each other to better understand economic and political situations, effectively being part of the solution as leaders.

Now more than ever it is imperative that policy makers strengthen cooperation between Jefferson-minded individuals and promote the public-private model. Substantial gains would result from new initiatives and legislator dialogue designed to deepen and re-energize the transatlantic economy through increased trade, higher investment, and stronger flows of knowledge. Otherwise, it will be today's emerging economies that establish tomorrow's global economic standards.

David Stott is an intern in International Relations at ALEC and a senior at Brigham Young University. He is pursuing a Bachelor's in International Relations with a minor in Business Management.

Prescription Assistance Programs:
A Critical Resource for Uninsured Americans

By Roba Whiteley

Millions of Americans find themselves unable to pay for healthcare. This lack of insurance can take its toll on an individual's health, leading to delay in preventative care, poor management of chronic conditions, and even death. It also has negative economic consequences. Sadly, 23 percent of uninsured adults say they did not fill a prescription in the last year because of cost.[1] Nearly 60 percent of this population skip or stop taking their medications because they cannot afford them.[2]

Several prescription assistance programs exist to help uninsured individuals and families better access the prescription medicines and products they need to stay healthy and to treat disease. One program, Together Rx Access, which is sponsored by some of the nation's leading pharmaceutical companies, helps eligible uninsured individuals gain access to immediate and meaningful savings on hundreds of prescription products right at their neighborhood pharmacy. In fact, about 10,000 people enroll in the program each week.

Individuals who enroll in Together Rx Access receive a free-to-get and free-to-use card that they bring to their neighborhood pharmacist along with their prescription and the savings are calculated right at the pharmacy counter. Most Together Rx Access cardholders save 25 to 40 percent[3] on brand-name prescription products. Savings are also available on a wide range of generics. Medicines in the program include those used to treat high cholesterol, diabetes, depression, asthma, and many other common conditions. The card is accepted at the majority of pharmacies nationwide and in Puerto Rico.

Individuals may be eligible for the Together Rx Access Card if they do not qualify for Medicare, do not have public or private prescription drug coverage, have a household income of up to $30,000 for a single person or $60,000 for a family of four (income eligibility is adjusted for family size), and are legal residents of the United States or Puerto Rico.

There are three easy ways to enroll:

- Visit Together Rx Access.com
- Call 1-800-250-2864
- Complete a short paper application and return it by mail

Legislators play an important role in educating potential enrollees about prescription assistance resources as they engage with the public on a regular basis. Simple action steps legislators can take to introduce their constituents to the program are:

- Distributing information packets about the program in their offices
- Including program information in newsletters and other informational materials
- Linking to TogetherRxAccess.com
- Providing the Together Rx Access toll-free number 1-800-250-2864 to eligible individuals
- Providing information about Together Rx Access at town hall meetings and other constituent events

Roba Whiteley is the Executive Director of Together Rx Access. For more information about Together Rx Access, visit TogetherRxAccess.com or call Niko Stemple, Chair, Government Affairs, Together Rx Access at 703-684-4836.

[1]The Uninsured: A Primer. Kaiser Family Foundation. October 2006. Page 7.

[2]Gaps in Health Insurance: An All-American Problem. The Commonwealth Fund. April 2006.

[3] Each cardholder's savings depend on such factors as the particular drug purchased, amount purchased, and the pharmacy where purchased. Participating companies independently set the level of savings offered and the products included in the program. Those decisions are subject to change.

Net-Neutrality Threatens Health Care Innovation

By David Myslinski

Telemedicine is quickly gaining traction as a vital tool in the doctor's bag; and, as new innovations become routine, doctors—as well as their patients—will only become more dependent on telemedicine in the future.

To see how telemedicine can transform an industry, simply look at radiology. For several years, CT scans have been accessible remotely over the Internet. Radiologists, regardless of location and time of day, have the ability to examine a high-quality digital image and report findings back in under an hour, as well as to collaborate with other experts around the world—all while reducing costs. Within the past decade, we have seen the first remote surgeries not only take place, but gain favor as technologies advance and the Internet's infrastructure becomes more robust.

By its very nature, telemedicine relies heavily on the near-instantaneous speed and immense capacity of the Internet, and will only require more bandwidth as it develops and becomes more widespread. While some technologies can tolerate a slower connection, such as Electronic Health Records (EHRs), much of the communication is bandwidth intensive and requires zero-latency. These real-time procedures include videoconferencing, monitoring of patients and remote surgery.

These are fantastic advances in the medical world, but future breakthroughs could come to a screeching halt if the government were to adopt so-called "network neutrality" regulations.

Government mandated network neutrality regulations would prohibit Internet Service Providers (ISPs) from managing their networks. But, it is reasonable and in all of our best interests that ISPs facing bandwidth constraints should give live, two-way telemedicine conferences priority over music file-sharing traffic. Additional regulations would only slow the expansion of broadband services and disproportionately affect rural areas that do not have easy access to medical specialists and which would benefit the most from telemedicine.

If the Federal Communications Commission (FCC) or Congress were to enact these regulations, doctors and hospitals would be forced to compete for existing bandwidth with people downloading movies, music, or other files—legal and illegal. When network providers are instead allowed to manage the web traffic running through their servers and prioritize it, services like telemedicine procedures can proliferate.

ALEC's *Statement of Principles on Health IT* affirms that any system should be "financed by all who benefit from the increased quality, efficiency and savings that result from such technology." By adopting network neutrality regulations, the FCC would not only go against the *Statement*, but also against ALEC's *Resolution on Network Neutrality*, which notes that "regulation of the Internet may interfere with future investment and innovations benefiting the health and well-being of its end user customers."

Government should strive to promote the competition and innovations that continue to push the boundaries in both telecommunications and healthcare. Adding growth-stifling regulations to the Internet, one of the most dynamic industries our nation has seen in recent years, will only hinder our nation's medical and technological competitiveness.

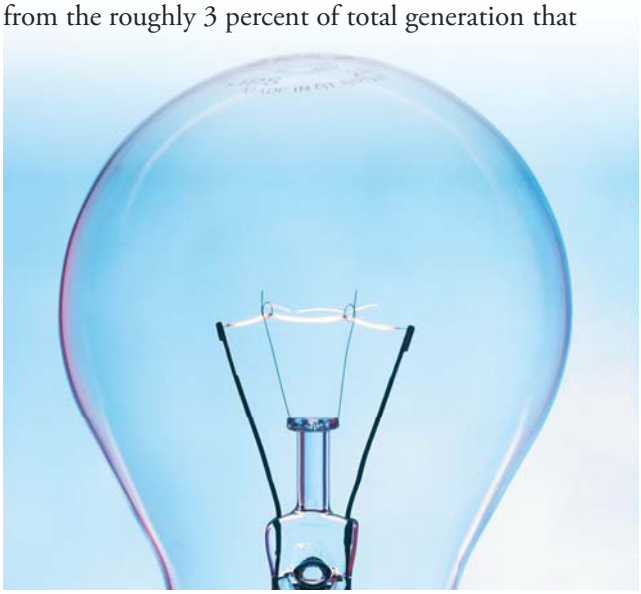
David Myslinski is the Legislative Assistant for ALEC's Health & Human Services, and Telecommunications & Information Technology Task Forces.

Let There Be Light:
Meeting Our Future Electricity Demand

By Matt Warner

Before the U.S. Congress's drilling moratorium expired at the end of September, the House passed a comprehensive energy package that was designed to appease offshore drilling supporters but, in fact, fell far short of Americans' expectations and failed to win favor in the Senate. The bill, H.R. 6899, offered little in offshore access but was loaded with subsidies for renewable energy and included a mandate for electricity providers to generate 15 percent of their energy from renewable sources by 2020. The provision was a revisit of a failed measure from 2007 that drew ire from a broad coalition of industry and state regulatory commissions who warned of negative impacts to consumers and workers.

At the time, the U.S. Chamber of Commerce warned that "a mandatory [standard] could raise electricity prices for all consumers, result in a wealth transfer among states, and impose new burdens on the reliability of the nation's electric grid." The Edison Electric Institute (EEI) concluded the mandate was "little more than an electricity tax" and could cost consumers billions of dollars. Today, EEI calculates a 15-percent requirement by 2020 represents a 400-percent jump from the roughly 3 percent of total generation that renewable energy sources now contribute to the grid. The United Mine Workers of America decried "a 'one-size-fits-all' federal mandate" and said states were better positioned to deal with energy portfolios.



Many states have developed their own portfolio standards based on their state's unique energy makeup. These state-level mandates impose costs of their own and beg revisiting during this time of economic distress. But a federal, one-size-fits-all standard could prove even more impractical. Every state that has adopted its own standards (more than half of states) includes at least one renewable source excluded from the federal definition. Daren Bakst, an analyst with the North Carolina-based John Locke Foundation, points out on the blog *EnvironmentNC* that hydropower is excluded even though it is a legitimate, renewable source of electricity. In a letter to Congress regarding a proposed federal standard, the state utility commissions of nine southeastern states, including North Carolina, explained that not all states are created equal when it comes to renewable energy sources. Most southeastern states, for example, enjoy little wind energy potential compared to states in the Midwest. States with fewer opportunities to develop sources at home will be forced to buy credits made available from neighbors.

The bigger problem overshadowing this federal effort, however, is a booming demand forecast for electricity. The latest assessment from the North American Electric Reliability Corporation (NERC) concludes that long-term capacity margins are inadequate to meet future needs and investment in infrastructure and new supply are needed. Simply put, we are not ready for the demand that's coming. In an article for Forbes.com, Mark Mills explains the problem:

> *Right now the nation has 760 gigawatts of power plants to meet current consumption, with another 154 in reserve capacity to maintain grid reliability. But in fact only 10 gigs is truly excess*

capacity. The other 144 is utterly essential to keep the lights on when unexpected demand arises from heat waves, outages or maintenance downtime. That reserve will begin to shrink quickly.

Others agree. A recent analysis from NextGen Energy Council finds U.S. baseload generation capacity reserve margins have declined precipitously to 17 percent in 2007, from 30-40 percent in the early 1990s. Experts say a 12-15 percent capacity reserve margin is the minimum required to ensure reliability. According to Mills, NERC estimates that over the next decade 135 gigawatts of new capacity will be needed to meet the growth in consumption. But right now plants producing only a total of 57 gigawatts are planned.

In an open letter to America's next president, a long list of the nation's veteran leaders including former Cabinet members, senators, national security advisors, and current business leaders put global demand for energy rising by more than 50 percent between now and 2030 and by as much as 30 percent in the United States alone. They warned that a failure to meet the growing demand could result in blackouts, brownouts, service interruptions, and rationing.

In light of this outlook, NERC's president Rick Sergel declared that, "we're to the point where we need every possible resource: renewables, demand response and energy efficiency, nuclear, clean coal—you name it, we need it."

The same conclusion has been reached independently at the state level. Recently, Arizona State University released a study assessing Arizona's energy future. The study's authors estimate that Arizona households and businesses will require an additional 20 million-megawatt hours of electricity over the next decade. To meet this challenge, the authors caution against abandoning conventional energy sources citing dramatic increases in electricity rates that would threaten economic growth. They conclude, "a headlong push now to build more renewable sources may be counter-productive by raising rates too high too fast," and "while increased use of solar and wind energy in Arizona does contribute to the state's power grid, these sources are incapable of meeting the future demand for electricity…from a current base of .03 of one percent."

The reality is that conventional sources of energy are needed and should be welcomed. In a presentation to ALEC at the 2008 Annual Meeting in Chicago, Dr. Frank Clemente, a leading expert with Pennsylvania State University's Institutes of Energy and the Environment, cited data from the Energy Information Administration (EIA) to demonstrate that conventional energy sources like coal, oil, and natural gas—which today account for 85 percent of America's energy—will still account for 83 percent of our energy supply in 2030.

Increased demand for electricity is a positive indicator of the world's progress. Access to electricity means a better quality of life across a multitude of measures. According to Dr. Clemente, people in societies with greater access to electricity eat better, drink cleaner water, are better educated, and live longer. Meeting a growing demand for electricity both at home and abroad is critical to economic growth and general prosperity. Barring or artificially discouraging viable sources of energy will only harm American consumers and low income people everywhere. Those who think we can afford to pick and choose our sources by federal mandate may soon find themselves whistling in the dark.

Matt Warner is the Director of ALEC's Natural Resources Task Force.

Getting Ethics Reform Right:

The Unintended Consequences of Burdensome Ethics Reform

By Jonathan A. Moody and Whitney DuPree

The confidence of American voters is dependent on a system of government that functions with integrity. ALEC Member and Mississippi Representative Michael Janus contended, "the American voter's confidence in their elected officials and the election process as a whole has diminished greatly." Scandals and abuses of power are often seen as the causes for this problem. Therefore, many legislators, at the federal and state levels, feel pressured into enacting ethics reform legislation. After these reform bills are enacted, many legislators discover the unintended consequences of these laws. Therefore, it is important to ensure there is a framework of accountability based on transparency, while providing enough flexibility for lawmakers to effectively do the work they were elected to do.

Referring to Mississippi's efforts in this area, Janus stated, "we have treaded carefully as we recognize that there exists a delicate balance in State Government between full transparency and accountability, paired with the need to allow the political system to run efficiently and effectively." He continued, "it's important to remove the burden of unrealistic rules and restrictions, which on paper may appear beneficial, but merely tend to further complicate the process."

The struggle to implement complex ethics reform legislation without unintended consequences has been evident recently in various states. In July 2007, Alaska House Bill 109, a broad ethics reform package, was enacted. The reform was created in response to an FBI raid of several state legislative offices on August 31, 2006. Rep. Richard Foster was personally affected by an unintended consequence of the "compassionate gifts" restrictions included in the 2007 legislation. The legislation defined "compassionate gift" as "a solicited or unsolicited gift intended to aid or comfort a recipient, or a member of the recipient's immediate family in contending with a catastrophe, a tragedy, or a health-related emergency." Foster, who suffers from a genetic kidney disease, was in need of a kidney transplant.

They found a match, but unfortunately, he was unable to receive the transplant because as a legislator, it was illegal for him to accept this "gift" from the donor—a legislative staffer. The law clearly stated that, "a legislator or legislative employee may not solicit, accept, or receive, directly or indirectly, compassionate gifts worth less than $250 that in a calendar year aggregate to $250 or more in value and are from the same person." Alaska's ALEC State Chair and House Rules Committee Chair, Rep.

John Coghill, responded to this unintended consequence by authoring House Bill 317, enacted February 2008. This bill eliminated the limit on compassionate gifts a legislator or legislative staff could "solicit, accept, or receive," while requiring reporting of such gifts within thirty days, so that the law would no longer prohibit Rep. Foster from receiving a kidney transplant.

Oregon has also passed overly restrictive ethics laws. Their reforms require public officials to name and disclose the financial records of many of their family members. This caused a significant number of legislators to believe their individual rights had been infringed upon. The bill was passed in June 2007, with an April 15, 2008 deadline to submit all requested information. According to *The Oregonian*, rather than disclose the information, more than 150 public officials resigned.

In Colorado, ethics reforms have added complications and additional requirements for legislators who wish to participate in valuable opportunities open to other states, including ALEC meetings. On November 7, 2006, Colorado voters passed the ballot initiative, Amendment 41, including a ban on gifts of $50 or more within a calendar year to a legislator or other government official (or their immediate family) unless there was equal or greater returned value. This includes compensation provided by ALEC for legislators to attend certain meetings and events. The ALEC State Chair for Colorado, Rep. Don Marostica, commented, "as the ALEC State Chair, it has been very difficult to get attendance from our legislators because so many are unable to pay their own way. Earning only $30,000 a year does not allow most ALEC members to spend the $2,000 - $3,000 that it takes—very unfortunate."

This has not kept Marostica from staying involved with ALEC. However, in order to attend certain ALEC events, he must be a presenter, as part of the official program, in order to comply with the law, and ensure other elements of the law are complied with. It can be easily seen that it would not be practically possible for each attendee to be a presenter. Therefore, this complication discourages Colorado legislators from becoming involved and benefitting from the collaboration provided by ALEC, with fear of not jumping through the right hoops to ensure compliance with the law.

We are all familiar with the rule we learned in elementary school, "if someone abuses a privilege, no one gets to enjoy it," but isn't it a little unrealistic for us to treat our elected officials like that? Whatever happened to the principles of individual responsibility? Can we not both preserve these key principles *and* maintain accountability and transparency in our government?

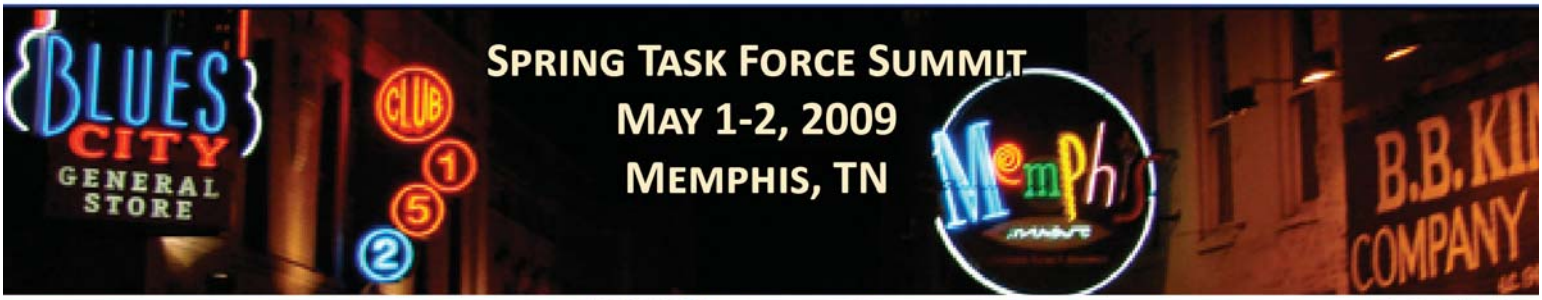
This is an important issue, and one we cannot afford to give over to rhetoric. Citizens absolutely have the right to expect ethical conduct from those they elect to represent them. Additionally, they do have a constitutional check against abuses of power—the right to vote. If elected officials are required to disclose their activities, constituents get to judge whether they deserve to continue in office. When you try to account for, and prevent all ethical problems, sometimes more problems are created along the way. That is why it is important for organizations such as ALEC to provide the opportunity for legislators to discuss the best ways to ensure integrity in government, while maintaining the founding principles of individual liberty and responsibility. If we get ethics reform right, we will be able to see a government accountable to its constituents, and free enough to effectively and efficiently serve those constituents.

Jonathan A. Moody is the Policy Coordinator at ALEC and oversees the Elections and Ethics Subcommittee within the Criminal Justice and Homeland Security Task Force.

Whitney DuPree is a Policy Intern at ALEC and a student at the University of Central Florida.

***NEW!** ALEC now has a subcommittee on Elections and Ethics within the Criminal Justice and Homeland Security Taskforce. The subcommittee will hold its first meeting at the 2008 States and Nation Policy Summit in Washington, D.C. on December 4, 2008. This will provide a forum for legislators to discuss the best ways to address these important issues. For more information on the subcommittee, contact Jonathan Moody, jmoody@alec.org.*

Upcoming ALEC Meetings



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